



State Employee Health Plans Can Be Leaders and Drivers of Value-Based Initiatives

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KEY THEMES

- State employee health plans cover a significant fraction of the commercially insured population—in 18 states, state employee plans cover over 10% of the commercial market. As large health care purchasers with a statewide pool of patients, state employee health plans are an often overlooked vehicle that states can use for improving their health care system and moving the commercial market forward on value-based reforms.
- State employee health plans have implemented reforms by themselves, in collaboration with other state agencies (generally Medicaid), or in broader multi-stakeholder collaboratives. Plans have seen particular success with reference pricing, limited networks, tiering, bundles, and accountable care models.
- Large commercial payers and purchasers can learn from the experiences of state employee health plans and their evidence on what works, and can also look to them as collaborators in multi-payer initiatives.

Introduction

Public and private employers continue to struggle with rising health care costs. Since 2012, the employee and employer share of health care costs for family coverage rose by 32% and 14%, respectively.¹ While this is slower than in previous years, costs continue to rise faster than inflation, and have for decades. These rising costs give employers strong incentives to look for strategies that help them manage costs while improving employee health. However, most lack the size and reach to have a significant impact on the commercial market on their own.

State employee health plans are an exception. They are often the largest commercial plans in the state, and their position in state government and in the commercial market allows them to play a critical role in payment reform and benefit design. New initiatives from these plans can improve the quality and value of care delivered to the plan's enrollees and to the broader state population.¹

This brief examines strategies state employee health plans have taken to improve quality and value, both on their own and through collaborative efforts. It was developed from interviews with state employee health plan directors, state leaders, and national experts, and also from published articles and reports about state employee health plan initiatives. Drawing on these materials, it highlights strategies that governors, state leaders, and plan administrators (both public and private) can use today as levers to transform health plans in their state, explaining the challenges and lessons learned in implementing new initiatives. It also outlines how state employee health plans can serve as a useful health delivery and payment reform laboratory that large purchasers and payers can work with and learn from.²

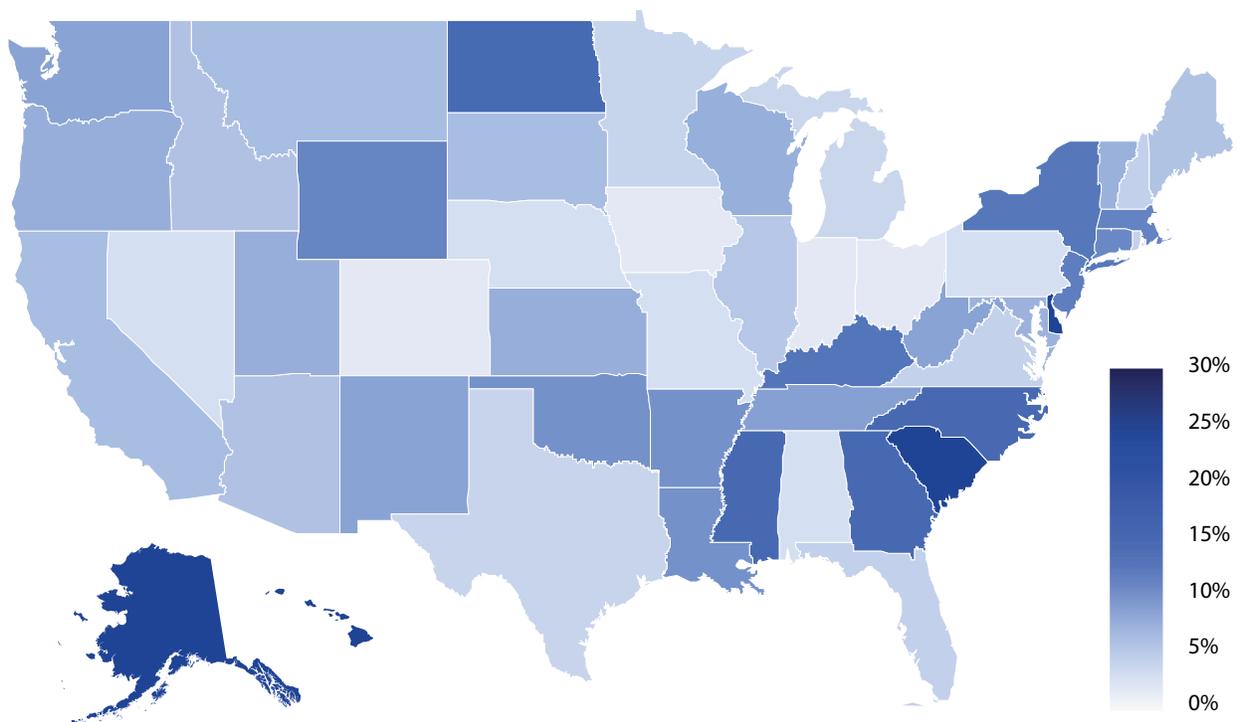
Why Are State Employee Health Plans Well Positioned to Improve Value?

Just like private employers, state employee health plans face rising costs and have significant motivation to bring them under control. In 2013, states spent \$25.1 billion on premiums,³ accounting for roughly 2% of state budget expenditures. Rising health care benefit costs squeeze funding for employee salaries, limit money for other state priorities, and threaten the long-term viability of these health plans.

State employee health plans have several characteristics that make them ideal for trying new payment and delivery approaches:

- Market power:** State employee health plans in 18 states insure at least 10% of their state's commercial insurance market, and they have significant market share in all states. (Figure 1 shows the size of state employee plans as a fraction of the state's commercial insurance market). Highly populated states like California and New York have the largest programs by total enrollment, but plans in states like North and South Carolina, Delaware, and North Dakota have a much larger share of the commercial market for many reasons, including a smaller percentage of the population with commercial insurance (i.e. more on Medicaid, Medicare, or other public programs).

Figure 1: State Employee Health Plan Enrollment as Fraction of State's Commercial Insurance Market



Author's Analysis

- **Consistency:** State employees stay at their jobs longer. A 2016 study found public sector employees had more than double the median tenure of private sector employees.³ In addition, many states' retiree health programs guarantee post-employment coverage until the employee reaches Medicare age, with many also providing wrap-around Medicare coverage. Longer relationships with individuals mean the state is more likely to reap the long-term benefits of investments in prevention, health improvement, disease management, and smoking cessation programs.
- **Geography:** State employee health plan members are often spread across a state, meaning the plan will have members in every major market (with a strong concentration in some areas, like the capital region).
- **Coordination:** Several state employee health plans work with other state health programs, notably Medicaid, and serve as key members of state-wide collaboratives.

KEY TAKEAWAY

State employee health plans are uniquely positioned to implement new payment and delivery reforms that can help them confront rising health care costs and maintain high-value plans.

The Challenge of Changing Cost Sharing in Plan Benefits

State employee health plans generally have more generous benefit packages than the average private employer. As of 2013, these plans had an average actuarial value—the percentage of costs for which the plan is expected to pay—of 92 percent, corresponding to a platinum rating on the Affordable Care Act's exchanges.² Eighty percent of state employees were enrolled in a plan with a deductible of less than \$500, and nearly half had no annual deductibles. States also paid a higher percentage (80 percent on average) towards the overall premium when compared to for-profit large employers, which pay an average of 73 percent.³

States may feel additional pressure to control costs and change their benefit structure if the "Cadillac tax" is implemented. This provision of the Affordable Care Act would tax health plans with benefits worth more than a set value. Given the high actuarial value of many state employee plans, limiting a plan's exposure to the tax may require drastic action.

Changing benefits could be controversial, though, as comprehensive benefit packages have been a tool for bringing on and retaining the best state employees. Further, benefit packages are often set through negotiation with state employee unions, who consider health plans an incredibly valuable part of an employer's benefit package. States have options beyond cost sharing, though, and should look toward options that help get more value for their money.

KEY TAKEAWAY

Whereas most commercial purchasers and payers have utilized higher cost sharing for several years, state plans have only started to do so, and they face specific challenges in implementing these changes.

What Do We Know About Value Initiatives Undertaken by State Employee Health Plans?

State employee health plans are already implementing a variety of payment reform and benefit redesign efforts. There is evidence that these options can encourage enrollees to choose higher value care and improve quality while reducing cost. Table 1 summarizes these types of initiatives and highlights examples of states that have tried them, along with the challenges these initiatives have faced. The remainder of the brief provides more details on specific examples of how many of these initiatives have worked.

Table 1: State Experiences Developing Value Initiatives and Challenges Faced (SEHP= State Employee Health Plan)

Value Initiative	Example State Experiences	Implementation Challenges
Bundled Payments	Working with state Medicaid program, TN's SEHP aims to have 75 bundles designed by 2020 and saved \$11.1 million in the first year of the program.	Choosing the episode; correctly choosing who is responsible for coordinating the bundle; how to set the benchmarks (historical vs. regional).
Limited/Narrow Networks	MA offered to pay three months of premiums if employees switched to limited network, saved money overall. NJ offers cash payment if employees switch.	Requires good cost and quality data at the provider level to assess which would go into limited network; can frustrate excluded providers.
Tiered Networks— Provider and Pharmacy	MA has implemented uniform tiering for specialty providers across plans. WA and NV taking similar approaches for specialty pharmaceuticals.	Requires significant data to develop the tiers. Risk of pushback if popular providers end up in higher tiers. Providers could dispute what data were used and how it was compiled.
Accountable Care Organizations (ACOs)	Successful SEHP ACO initiatives (OR, VT) have generally been multipayer efforts, emphasizing coordinated action to reform care delivery.	Can require significant infrastructure cost to form an ACO; need to align with other ACO programs run by commercial and public payers.
Patient-Centered Medical Homes (PCMHs)	AR has multi-payer PCMH effort with their SEHP—majority of providers and patients in the state participate.	Difficult for smaller practices to shoulder administrative burden. Requires culture shift from physician-based to team-based care.
Reference Pricing	CA initiative for joint replacement and AR initiative for drugs have both seen cost savings, mirroring private sector success.	Services need to be “shoppable,” and only one-third of health services are. Transparency tools needed for price comparisons.
Direct Primary Care Services	States have contracted with specific organizations (NJ & RHealth) and with specific clinics (MO, MT) to offer full array of primary care services.	While it could allow for better provision of primary care, some people may have a long-term PCP and not use the service.
Inter-Agency Coordination	SEHPs in OR and WA both work extensively with state Medicaid organizations on bulk purchasing and joint initiatives.	Requires substantial coordination among state agencies, potentially legislative approval if agency restructuring.
Accountable Communities For Health	MN has developed common measures, improved data exchange, and worked with community partners to target high-need target populations	Have to coordinate across multiple agencies beyond what a normal ACO coordinates (providers and social service organizations).

Identifying High Value Networks of Providers

Given the variability in quality and value among providers, state employee health plans can encourage enrollees to utilize higher-quality or higher-value providers through limited network design. Such designs have become very common among exchange plans. Many individuals are willing to accept a more limited network— often less than 50% of area providers—in exchange for lower premium costs.⁵

Beginning in 2011, the Massachusetts Group Insurance Commission (GIC), which administers their state employee plans, offered 6 limited network plans out of 11 total state employee plan options. (Five such plans remain today³.) The Commission gave flexibility to health plans in defining a limited network, with guidance that it would include no more than 75% of hospitals in the network, but still ensure sufficient coverage for the plans' service areas. To encourage enrollees to try these plans in 2012, Massachusetts offered to pay for three months of premiums if an employee selected one of

them; 11% of workers switched.⁶ Depending on an employee's initial coverage and the number of dependents on the plan, the change saved anywhere from \$268 per month to \$956 per month per employee in total contributions.⁶

Enrollees in these plans had 41% lower spending, achieved mainly through reduction in emergency department use, specialist visits, and hospital use. This switch caused an estimated 4.2% reduction in spending for the Commission, and saved money for the state even when accounting for the increased spending for incentives.

Limited network plans on the individual market have had a similar effect in reducing premiums. A 2017 study of limited network plans offered on eight states' exchanges found that premiums were 5.7% lower for limited hospital network plans and 9.4% lower for limited physician network plans compared to broad networks. Combined, this equaled a \$527 per year premium difference.⁷

However, limited network plans could pose problems if not implemented correctly. States must be vigilant about ensuring that the networks offered are reasonable for those purchasing them. If a patient does not have access to in-network providers in their geographic region, they would face higher out-of-network costs.⁸ It may be easier to ensure network adequacy in large metropolitan areas, where enrollees have access to multiple hospitals and providers, but may be more difficult in rural areas. Limited network plans also need to have frequently updated provider lists. If consumers rely on these lists to determine where they can access care, their attitude toward a plan can deteriorate quickly if a listed provider is no longer contracted.

Ultimately, the appeal of a limited network plan to an enrollee will depend on his or her priorities, and will not solve cost problems for all state employees. Many employees may have a regular physician or preferred specialists, especially if they have a history of chronic conditions. They may be unlikely to switch if they value the provider relationships they already have developed. Furthermore, limited networks may be impossible in some rural areas, where locking out a hospital for high prices may leave enrollees with no other options.

KEY TAKEAWAY

Employees have accepted more focused networks in exchange for lower premiums as long as they felt they had sufficient access to care. Massachusetts achieved savings through limited network plans, and got greater enrollment through premium holidays for those who switched.

Tiering

Tiering offers another strategy for steering enrollees toward high-quality providers and lower-cost pharmaceuticals. In contrast to network design where a given provider is either in network or not, tiering establishes different cost sharing for specific tiers of providers based on quality or value metrics. Many state employee plans already have some level of tiering in place for pharmaceuticals. Several have also implemented tiering initiatives for providers in recent years, showing there is still room for new action. This mirrors the broader employer community, where almost 15% of all employers in 2016 used

a tiered provider network in their largest health insurance offering.²

Beginning in 2005, Massachusetts' Group Insurance Commission implemented the Clinical Performance Improvement (CPI) tiering program, focusing on high-volume specialties. The Commission aggregated claims data from all of their plans to compare specialty providers to peers in the same specialty, using quality measures and cost-efficiency scores.^{9,10} The Commission also consulted local and national specialty societies to help determine appropriate measures to use in constructing each specialty's tiers. Using this analysis, it classified about 15% of providers in Tier 3 (Standard), 65% in Tier 2 (Good), and 20% in Tier 1 (Excellent).¹¹ The tiers were implemented uniformly across all plan options, so that providers experienced the same incentives and received the same feedback regardless of the employee's plan choice.

Early estimates found that new enrollees searching for a physician did choose higher performance tier providers and saved themselves money (an average of \$30-\$60 for top-tier plans compared to standard plans), but many existing enrollees showed high loyalty to their current specialists and did not switch.⁹ To provide more incentives to use higher tiered clinicians, the Commission introduced a new co-pay structure, with specialist co-pays increasing from \$25/\$35/\$45 (for Tiers 1, 2, 3) in FY 2015 to \$30/\$60/\$90 in FY 2016.¹² This example highlights an important lesson for plans considering implementing a tiering program—if the incentives are too small, employees are unlikely to consider switching providers; if the incentives are too high and popular providers are in the lower performance tiers, there is a risk of employee backlash. Further, accessing the data from across all plan options can be challenging, and many purchasers may not have the analytic capacity to administer a complex tiering program.

Building on common pharmacy tiering programs, some state employee health plans have introduced novel approaches to further encourage utilization of effective medicines (drawing on the lessons of value-based insurance design). Washington State offers a value-based tier to encourage the use of these therapies for common conditions, like high cholesterol, diabetes, and depression. The value tier has a lower coinsurance (5%) than even the generic drug tier (at 10%) and is not subject to the deductible.¹³ This tiering approach ensures that cost sharing does not prevent people from using medicines that effectively manage chronic conditions (and thereby reduce the total cost of care).

KEY TAKEAWAY

Massachusetts created uniform tiers for specialty physicians across all plans options, which encouraged enrollees to use higher performance providers. However, provider loyalty, data availability, and analytic capacity are challenges for others employers considering implementing this type of program.

Reference Pricing

Reference pricing is a benefit design intended to encourage consumers to shop for procedures and to put pressure on high-cost providers to lower prices. It occurs when a health plan sets a maximum contribution it will make towards procedures like joint replacements, colonoscopies, cataract removal surgery, and other elective services. If an enrollee receives the service from a provider who charges more than the reference price, the enrollee must pay the difference. The key is that the procedures involved must be “shoppable” (and some studies suggest only one-third of health services are^{14,15}), available from multiple providers, and easily comparable.

California’s state employee health plan administrator, CalPERS, began using reference pricing in 2011 for joint replacement. Since then, it has expanded the program to include other procedures like colonoscopies and cataract surgeries, and has brought down costs for both CalPERS members and the health

system more broadly. A 2015 study found CalPERS saved \$7 million and prices dropped 17.6% for knee surgery and 17% for shoulder surgery, largely due to lower cost providers offering the procedures in ambulatory surgical centers.¹⁶ A later study estimates spillover effects to patients covered by other plans, with medical spending across the state dropping an additional \$4.5 million due to lower provider prices.¹⁷

Arkansas developed a similar reference pricing program for drugs, basing the price on a low-cost drug within a specified class in which no drug is shown to be therapeutically best. The plan pays a specified cost per pill and the enrollee is responsible for the remainder. In 2016, the reference pricing program included 11 classes of drugs. A study of the program’s impact on proton pump inhibitors (PPIs) found that program costs for PPIs had been cut almost in half after 3½ years, saving \$7.2 million over that period compared to similar plans without this program.^{18,19}

Commercial plans in the private sector have seen similar success with reference pricing. A study of an initiative implemented by the RETA Trust, a self-insured association of 55 Catholic organizations, found that the prices RETA paid for drugs were approximately 14% lower than an organization that did not use reference pricing, saving the organization \$1.3 million. Enrollees were also more likely to select the lowest-cost drug.²⁰ These results mirror studies done worldwide on reference pricing, another sign that it shows broad promise for bringing down prices for both procedures and prescription drugs.

Reducing Specialty Pharmacy Costs

Many employers are struggling with higher specialty prescription drug costs. Nevada’s state employee health plan—the Public Employees’ Benefits Program—examined specialty drugs administered in a medical setting (hospitals, physician offices, and freestanding infusion centers), and found that costs charged for these specialty drugs varied dramatically between different sites of care. They experimented with requiring specialty drugs administered in a medical setting for their plan beneficiaries to be purchased either through the plan’s specialty pharmacy associated with their pharmacy benefit manager contract, or if the site of care refuses, negotiate a cost for the claim at or below the specialty pharmacy’s price. If the site of care refuses either option, the plan contacts the member and coordinates a mutually agreeable switch to another provider who did agree to one of the options above. Nevada’s work on this innovation saved approximately \$800,000 and won them the 2017 State and Local Government Benefits Association (SALGBA) Challenge award.^{21, 22}

KEY TAKEAWAY

Reference pricing approaches have saved costs for California and Arkansas on surgeries and low-cost drugs, respectively. Reference pricing can work, but services must be “shoppable.”

Multipayer Approaches to New Payment Models

Purchasers and payers across the country are implementing a variety of new payment models that seek to provide incentives for clinicians and health care organizations to deliver coordinated, high-quality, efficient care, and make them more accountable for a person’s health. The federal government has set a goal of having 50% of payments made through alternative payment models in 2018.²³ Similarly, the private sector is beginning to embrace alternative payment models, with one survey showing that in 2016, payment through alternative payment models accounted for 1/5th of commercial health spending.²³

Given the payment reform activity occurring across the public and private sectors, it is not surprising that there are opportunities for collaborations with state employee health plans. For example, Tennessee’s state employee health plan is a part of a bundled payment initiative led by the state’s Medicaid program. As of the end of 2016, Tennessee offered bundled payments for eight procedures and plans to have 75 episodes designed by 2020. Results from the first year of Tennessee’s initiative showed cost decreases in each of the procedures for which bundles were developed and reduced costs by \$11.1 million.²⁴

The Washington state employee health plan, administered by the Public Employees Benefits Board (PEBB), also implements bundled payments as part of its participation in a statewide collaborative (the Dr. Robert Bree Collaborative).²⁵ The Bree Collaborative, consisting of stakeholders from across the state, identifies important areas of care for improvement and develops recommendations for action. Recently, the Committee selected lumbar fusion surgery, which has an average cost of \$80,000–\$120,000; identified a payment model that could support high quality care; and encouraged members to implement it. In early 2016, the Washington state employee health plan implemented the Bree’s bundled total joint replacement surgery model for enrollees and negotiated with major practices to use it.²⁶

Collaborations like these help develop the critical mass of plans using payment reform needed to help change provider behavior. For example, Tennessee’s Medicaid and state employee health plan enrollees account for 26% of the state’s total population, creating significant incentive for providers to use bundled payments.

KEY TAKEAWAY

Multipayer initiatives show how collaboration can ensure a critical mass of purchasers—including state employee health plans—adopt new payment models.

State employee health plans are also implementing accountable care models along with their state Medicaid program and other payers. For example, Oregon’s Public Employees Benefit Board has integrated its plan with the state’s Coordinated Care Organizations (CCOs), originally designed to serve the state Medicaid program. CCOs bring together all types of providers—physical, mental, behavioral, and dental—to help improve care coordination and patient management of chronic conditions. They have seen a higher percentage of total medical spending allocated to primary care and a higher percentage of non-claims-based payments in overall primary care spending.²⁷

Beyond implementing a specific payment model, state employee plans can collaborate more broadly with other state health programs. The Washington State Health Care Authority (HCA) is one of the most ambitious collaborations, in which Medicaid and the Washington Public Employees Benefits Board are under one organization. Combined, the organization purchases \$10 billion a year for one in three state residents. The Authority’s leadership says the state employee plan offers a lever to gain the attention of providers. The Washington Public Employees Benefits Board is not only a large program, but offers commercial-level reimbursements that are often significantly higher than Medicaid reimbursements. Washington can lead with its state employee health plan, get buy-in from insurers, and apply similar contracts or negotiations to the state Medicaid plan. The Authority has currently coordinated 50 measures into the public employee plan and the Medicaid contract, with many of them tied to payment. The Washington Public Employees Benefits Board has also been heavily involved in the state’s health reform leadership; for example, they have served as a key organization on the Governor’s informal cross-agency “Kitchen Cabinet,” which meets monthly to coordinate Washington’s State Innovation Model grant.²⁸

KEY TAKEAWAY

While barriers to inter-agency collaboration (between state employee plans and Medicaid) can be high, often requiring legislative approval and reorganization, collaboration can offer benefits by maximizing the purchasing power given the large number of people covered.

Participating in Multi-Stakeholder Health Collaboratives

Payment reform can often face barriers due to the difficulty of aligning incentives for stakeholders that typically operate independently and often competitively.²⁹ Multi-stakeholder health collaboratives—broadly, when health stakeholders from different sectors (employers, policymakers, providers, etc.) voluntarily collaborate to improve health care payment and delivery—can serve as trusted, neutral vehicles for aligning around solutions to common challenges.³⁰ They also offer complementary skillsets specifically relevant to payment and delivery reform, especially infrastructure work on data analytic capacity, public and private performance reporting, quality improvement, and practice transformation knowledge.³¹ One key theme emerged from examining such collaboratives—state employee plans can play key leadership roles in designing payment and delivery reform initiatives used amongst many stakeholders, in large part due to their purchasing power and statewide reach.

For one example, Washington's Public Employees Benefits Board plays an important role with the Washington Health Alliance (WHA, also known as the Alliance), a purchaser-led collaborative that works with 175 member organizations across the state, and represents key stakeholder groups.³² A leader of Washington's Health Care Authority is an active participant in the Alliance's Purchasers Affinity Group, and until recently, co-chaired the Group. The Purchasers Affinity Group provides a regular forum for employers and labor trusts to accelerate payment reform, such as sharing best practices of consumer

health engagement, learning about value-based benefit design, getting employers into the Alliance's medical home pilot, and aligning around messaging strategies to health plans about improving market efficiencies, among others.³³

The New Mexico Coalition for Healthcare Value (NMCHCV) is an employer-led, state-wide multistakeholder health collaborative working towards health care value and emphasizing efficiency, quality, and decreasing costs, with payment reform part of the dialogue. Its board members include three of the four Interagency Benefits Advisory Council (IBAC) members (state public purchasers) as part of their Coalition: the New Mexico Public School Insurance Authority, New Mexico Retiree Health Care Authority, and Albuquerque Public Schools. Most of the Coalition's employer members are public/governmental entities largely due to the employer makeup in the State, which includes a high proportion of public employers. Their current initiatives include working with major state employee plan organizations to assist in writing value-based payment reforms into health plan contracts to manage high-cost chronic illness and acute care episodes (a key annual action item for state plans).

Despite the involvement and leadership of New Mexico's major state employee plans in the New Mexico Coalition and state payment reform, one challenge is that the commercial market in the State is small compared to the public payers such as Medicaid and Medicare. New Mexico is a Medicaid expansion state, and therefore Medicaid covers almost half of the state's residents. In states like these, it is critical for coalitions and state employee health plans to also consider collaborating further with Medicaid to have a broader impact.

KEY TAKEAWAY

As large commercial purchasers, state employee health plans are well-positioned to serve in leadership roles in multi-stakeholder collaboratives that align payment reforms.

Challenges for States and Large Purchasers in Implementing New Initiatives

It would be tempting to suggest that state employee health plans—or any large purchasers—should undertake all of the above initiatives. In reality, this is not practical. Starting too many new initiatives would overburden providers and make it less likely for any individual initiative to achieve positive results. Each purchaser should instead identify specific priorities and implement targeted strategies that utilize their strengths.

State market context is also important. Whether the state has consolidated provider markets, has access challenges (like in rural states), or a history of collaboration will help determine the specific problems the plan should address and what levers can help solve them.

Purchasers should also work together to help build on the limited evidence base on these initiatives.^{34,35} Such evidence is crucial to understand whether they are actually changing provider behavior, improving patient outcomes, or improving value. There are opportunities to make it easier to develop evidence, and this evidence can be used to refine the design and implementation of future models.

State employee health plans also have limitations that other commercial plans do not face. Most notably, they have to account for politics, and the perspectives, goals, and ideologies of the elected officials that have authority over the plans. This affects not only the specific tactical steps the plan can take (like changing payment or mining specific data), but also the broader aims for reform. For example, an elected official may want the state employee plan to maintain benefit levels in order to improve state employee morale (therefore limiting any reforms), while another may see changing the state employee plan as a vital part of a broader health reform effort. Further, elected officials change regularly, and this may make it difficult to implement longer term initiatives if they lose critical support. State employee health plans also have to balance competing stakeholder needs and concerns, as those stakeholders may reach out to their elected officials to block undesired reforms. Political will unsurprisingly makes a significant difference.^{36,37} Successful initiatives generally have support from the state government leadership and stakeholders.

With most state employee plans covering retiree health benefits, these plans have also been affected by the Governmental Accounting Standard Board's Statement 45 (GASB 45).³⁸ As of late 2006, GASB 45 requires large public employers annually to calculate and report what contributions are necessary for financing future retiree benefits for workers in the current year, and for compensating for all unfunded liabilities over a 30-year period. These standards influence state and local governments' credit and bond ratings. Prior to 2006, unfunded liabilities were typically not reported, and GASB 45 made future costs more visible. This puts significant pressures on states and local governments—and thus state employee plans—to reduce costs for retiree health care and to investigate future health care costs, which may result in cuts to benefits. This further creates tension between state employee plans, their overseeing governmental bodies, employees, and their unions.³⁹

Finally, all state employee health plans must account for the fact that employees often value their health benefits, which are also often recruitment and retention tools. Health benefits have historically been rich to offset lower employee salaries. Changing health care benefits could remove this recruitment tool and could risk damaging relationships with state employee unions, who have often prioritized health insurance benefits in overall negotiations.

KEY TAKEAWAY

No payment reform initiative is one-size-fits-all, as the context of each state employee health plan's politics, history, and markets widely differ. The same is true for large purchasers. However, understanding these limits can help better target strategies that maximize strengths.

Factors That Affect How a State Employee Plan Implements Payment Reforms

State employee health plans are not homogenous, and they have different structures (and different names) depending on the state. These factors affect whether a state can implement a given payment reform or how it would operationalize a reform. Successful payment reforms will be tailored to account for these different attributes.

- **Size:** While these plans are consistently large, some may only include some state employees, while others may include local government employees, the state university system's employees, retirees, and different types of dependents. Larger risk pools will have greater ability to affect the market with a payment reform.
- **Centralization:** Another factor affecting their market power is whether all state employees are in one risk pool or if they are split among programs.
- **Risk:** Many state employee plans are self-insured, but not all. Those that are fully insured will need greater partnerships with their insurance plans.
- **Organization:** Some state employee plans are part of a health authority along with the Medicaid program and other state health programs. This could make it easier for them to coordinate their payment reforms with Medicaid. Other state employee plans are in separate departments or separate boards, and those may face organizational challenges to collaboration.
- **Premiums, Plan Choices, and Benefits:** In implementing new benefit designs, the state will have different options depending on how benefits and premiums are currently structured.
- **History:** Some state plans have a history and tradition of being an active purchaser, which makes it easier to take on new initiatives. Others are just starting to play a more hands-on role.

Conclusion

State employee health plans are large purchasing entities that have often been overlooked as a vehicle for improving a state's health care. They have a unique ability to experiment with new payment approaches, benefit designs, provider networks, data analysis, and collaborative efforts with other state agencies and stakeholders. In particular, reference pricing, tiering, and limited networks are benefit redesign approaches that have successfully delivered better value care, with bundles and accountable care models representing viable options for

payment reforms. Large purchasers and payers should learn from the experiences of state employee plans as well as look to such plans as a potential collaborator in the effort to drive health system transformation. The more purchasers are involved in developing new value-based care models and collaborating with peers, the better chance all purchasers will have to bring costs under control, improve quality and outcomes, and give value-based initiatives the best chance to succeed.

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